MENTAL HEALTH INITIAL LICENSURE APPLICATION PACKET

Revised 11/01/2007

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Mental Health Licensure and Certification Section

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Mental Health Licensure and Certification Section
2718 Mail Service Center ■ Raleigh, North Carolina 27699-2718
Courier Number 56-20-05
Michael F. Easley, Governor | Dempsey Benton, Secretary | Stephanie Alexander, Chief
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Memorandum

To: **Mental Health, Developmental Disabilities, and Substance Abuse Facility Licensure Applicants**

From: **Mental Health Licensure and Certification Section**

Enclosed you will find an Initial Licensure Application Packet. Included in this packet are the following:

- **Licensure Application Process**
- **Frequently Asked Questions**
- **Initial Licensure Application**
- **Photographs sheet**
- **Mental Health Survey**

Please read the enclosed information carefully. This information will help you determine if the services you propose to provide are licensable under mental health/developmental disability/substance abuse (MH/DD/SAS) rules, as well as the type of facility or service you may be interested in licensing. This packet also includes information about the fees associated with different types of licenses. MH/DD/SAS service providers must pay the required fees and be in compliance with applicable licensure rules prior to issuance of a license.

The following publications from the Division of MH/DD/SAS are essential in formulating the REQUIRED Operations and Management Policies, Guidelines and Procedures:

1. **Rules for Mental Health, Developmental Disabilities and Substance Abuse Services, Title 10A NCAC Chapter 27, Subchapter G (APSM 30-1), cost $5.75;**
2. **Client Rights in Community Mental Health, Developmental Disabilities and Substance Abuse Services, Title 10A NCAC Chapter 27, Subchapters C, D ,E, and F (APSM 95-2), cost $3.00;**
3. **Service Records (APSM 45-2) cost $5.00;**
4. **Confidentiality (APSM 45-1) cost $1.50.**

The publications above may be downloaded free of charge from the internet at www.ncdhhs.gov/mhddsas/statspublications/manualsforms/

These publications may also be ordered from the Division of Mental Health for a charge from the DMH Communications & Training Section: Phone: (919) 715-2780, e-mail: contactdmh@ncmail.net, mailing address: 3022 Mail Service Center, Raleigh NC 27699-3022. Walk-in address is 325 N. Salisbury St. Suite 1168, Raleigh, NC. Payment accepted by check or money order. Cash or credit card payments are not accepted.

LICENSE APPLICATION PROCESS

License Application Procedure

In order to apply for a license from the Division of Health Service Regulation to operate a mental health facility as required under General Statute 122C, you must do the following:

1. Complete the application
   (a) 24-hour Residential Programs:
   - Take the completed application (not whole packet) to your local zoning office and obtain zoning approval. Attach the zoning approval letter to the application.
   - Take the completed application (not whole packet) to your catchment area Local Management Entity office and obtain a Letter of Support as per Session Law 2005-276. Attach LME support letter to the application.
   - Submit items required by DHSR Construction Section listed in **Requirements for 24-hour Residential Programs** box below.
   - Include annual fee upon submitting all items.

   (b) Day Programs:
   - Take the completed application (not whole packet) to your local zoning office and obtain zoning approval. Attach the zoning approval letter to the application.
   - Submit all items listed in **Requirements for Day Programs** box below, including approved Fire Marshal's , Sanitation and Building Officials' inspection reports as required.
   - Include annual fee upon submitting all items.
2. Write a letter briefly describing the services to be offered by the facility.
3. Develop written policies and procedures for your services/program, but do not submit them with the application, as they will be reviewed at a later date.
4. Send application with required information to: Division of Health Service Regulation
   MH Licensure & Certification Section
   2718 MSC
   Raleigh, NC 27699-2718
7. Make check payable to: **NC Division of Health Service Regulation**

Note: Before construction of a *new* facility, you must submit blueprints and receive approval from the DHSR Construction Section. For information contact DHSR Construction at #919-855-3893.

Requirements for 24-hour Residential Programs—Existing Structures

Submit the following:

1. A floor plan that specifies the following:
   a. All levels including basements and upstairs.
   b. Identification of the use of all rooms/spaces.
   c. Dimensions of all bedrooms, excluding any toilets, bathing areas and closets. Clarify double or single occupancy.
   d. Location of all doors and the dimensions of all exterior doors.
   e. Location of all windows including the dimensions of bedroom windows and sill height of bedroom windows above the finished floor.
   f. Location of all smoke detectors noting whether they are battery operated, wired into the house current with battery backup, and if they are interconnected.
2. Exterior photos of each side of the building.
3. Interior photos of the kitchen, living areas, bedrooms, and any other rooms.
4. Directions from Raleigh or a map from the nearest major highway, street or intersection clearly showing the location of the facility.
5. **Local Zoning Department approval** for the proposed use**.**

Requirements for Day Programs

Submit the following:

1. A floor plan of the entire building or floor within the building of the space to be licensed that specifies the following:
   a. Identification and dimensions of rooms to be licensed.
   b. Exits from the licensed space and building.
   c. Toilet areas and other required support spaces.
2. Exterior photos of each side of the building.
3. Interior photos of the proposed licensed space.
4. Directions from Raleigh or a map from the nearest major highway, street or intersection clearly showing the location of the facility.
5. **Local Zoning Department approval** or verification the facility is classified under building/planning for intended use.
6. Current **local Fire Marshal's Inspection Report for the building**.
7. Current **local Sanitation Inspection report** if serving any food.
8. **New Construction/Renovation:** the **local Building Officials approval.**
9. **Existing Structure**: If this is an existing Business Occupancy building (as classified under the North Carolina state building code) and it is only a change of tenant use (for a program that is classified as a 'Business Occupancy use') approval from the local Building Official may **not** be required. Contact your local Building Official and provide them with a copy of your application to verify if your program is classified as a Business Occupancy and if they need to provide any type of documentation. NOTE: Any Day Treatment Program for Children and Adolescents cannot be located in a building classified as a Business Occupancy. These programs are required to meet either Group E-Educational Occupancy or Group I-4 - Child Daycare Occupancy under the NCSBC.

License Application Checklist

Incomplete applications will be returned to sender, without processing, accompanied by a letter explaining the incorrect or missing information. Please complete the appropriate checklist prior to submitting your license application.

24-Hour Residential Checklist		
	Item	**Completed**
1.	Cover Letter	
2.	Completed Initial Licensure Application (form DHSR 4080),	
3.	LME Support Letter	
4.	Annual Fee	
5.	Floor Plan with dimensions (specify residential)	
6..	Pictures (Interior & Exterior)	
7.	Zoning Approval (original) ***Required for application to move forward***	
8.	Directions to Facility	

Day Program Checklist		
	Item	**Completed**
1.	Cover Letter	
2.	Completed Initial Licensure Application (form DHSR 4080),	
3.	Floor Plan with dimensions (specify residential)	
4.	Annual Fee	
5.	Pictures (Interior & Exterior)	
6.	Zoning Approval (original) ***Required for application to move forward***	
7.	Directions to Facility	
8.	Fire Inspection (clear copy or original)	
9.	Sanitation Inspection (clear copy or original) if serving food	
10.	Building Inspection (original) if applicable	

License Fees: Annual & Construction

The Current Operations and Capital Improvements Appropriations Act of 2005 revised the annual license fee structure. All fees have increased, including licensure fees. This statute became effective October 1, 2005. NC General Statute 122C-23 prohibits the issuance of the license until the license fee is paid.

The Current Operations and Capital Improvements Appropriations Act of 2006 instituted an annual license fee for all non-residential facilities effective July 1, 2006.

NOTE: In addition, the Appropriations Act of 2005 revised NCG.S. 122-C 23 to mandate that licenses must be renewed annually and will continue to expire at the end of the calendar year.

Please submit Licensure fee with application. Do Not submit Construction fee. Construction will bill you for applicable fee prior to conducting their site visit.

Annual Fees: Following is a list of types of facilities that require an annual fee, including the base fee and the per bed fee.

Type of Facility	Number of Beds	Base Fee	Per Bed Fee
Non-residential Facilities	0	$175.00	N/A
Residential Facilities (Non-ICF/MR)	6 beds or less	$250.00	$0
Residential Facilities (Non-ICF/MR)	7 beds or more	$350.00	$12.50
ICF/MR* Facilities	6 beds or less	$650.00	$0
ICF/MR* Facilities	7 beds or more	$650.00	$12.50

*ICF/MR: Intermediate Care Facility for the Mentally Retarded, a specialized Medicaid facility requiring a Certificate of Need from the DHSR Certificate of Need Section.

NOTE Effective March 1, 2006: Annual license fees that accompany an initial license application or a license application for a change of ownership will be pro-rated based on the month the application is mailed and postmarked during the year. In order to determine the amount of the license fee that must accompany the application, please use the following formula:

APPLICATIONS SENT AFTER OCTOBER 1, 2007: Please send the entire annual fee for 2008, and your license will have an expiration date of December 31, 2008.

Multiply the annual license fee amount by the factor below, which corresponds to the month the application will be mailed and postmarked:

Month	Factor
January	**1.0**
February	**0.92**
March	**0.83**
April	**0.75**
May	**0.67**
June	**0.58**
July	**0.5**
August	**0.42**
September	**0.33**

For example, if the annual license fee for the facility is $250 and the application will be postmarked on August 21st, a check for $105.00 must accompany the license application {$250 x 0.42 (factor for August) = $105}. Round to nearest dollar amount.

Construction Fees: In addition to the license fee, the DHSR Construction Section has a one-time, per project fee to review the physical plant requirements. You will receive an invoice from the Construction Section for the appropriate fee. Following is a list of fees:

Type of Facility	Number of Beds	Project Fee
Non-ICF/MR Facilities	1-3	$100.00
Non-ICF/MR Facilities	4-6	$200.00
Non-ICF/MR Facilities	7-9	$250.00
ICF/MR Group Homes	1-6	$300
Other Residential	10 or more	$250.00 + $.075/sq.ft. project space

Contact Information

Please contact the Construction Section at (919) 855-3893 or the Mental Health Licensure and Certification Section at (919) 855-3795 with any questions. Direct all questions concerning the licensing process to the Mental Health Licensure and Certification Section Raleigh office at (919) 855-3795 or Asheville office at (828) 681-9898. For further information, the DHSR web site address is: www.ncdhhs.gov/dhsr/.

Licensing Process

Provider Action	DHSR Action
Submit: • completed application • zoning approval • LME support letter (residential only) • applicable inspections • licensure fee	**MH Licensure & Certification Section:** ▪ Reviews application for completeness and process application ▪ Return incomplete application packet to sender. ▪ Forwards completed application to DHSR Construction Section
▪ Pay construction fee after receiving Construction invoice. ▪ Meet with DHSR Construction Inspector on site for physical plant review.	**DHSR Construction:** ▪ Invoices applicant for project fee. ▪ Places applicant on site-visit list after receipt of project fee. ▪ Reviews blue prints/floor plans, makes site visit, determines compliance, ▪ If in compliance, recommends building for licensure to MH Licensure and Certification Section. ▪ If deficiencies found, DHSR Surveyor may need to conduct another on-site visit to verify compliance.
▪ Meet with MH Licensure & Certification Section Surveyor for policy and personnel review.	**MH Licensure & Certification Section** ▪ Reviews license application packet and contacts provider to schedule a review. ▪ Review will include: 1. Policies and Procedures as set forth in 10A NCAC 27G (APSM 30-1) 2. Client Rights Policies and Procedures as set forth in 10A NCAC 27C, D, E, F (APSM 95-2) 3. Personnel Requirements as set forth in 10A NCAC 27G .0202 4. Medication Administration and Client Rights Training 5. Program Specific Training specified in rule (i.e. confidentiality, symptoms of substance abuse, development of individual treatment plans, etc.). ▪ Recommends license approval when in compliance. ▪ Generates and mails license to licensee at mailing address on application.

FREQUENTLY ASKED QUESTIONS

Below are a number of questions routinely asked regarding licensure and the provision of mental health services followed by a response in *italics*.

1. **Where and how do I get clients?**
   Clients are usually referred to a provider from the Local Management Entity (LME). LMEs serve people residing in their geographic area and are required to contract with licensed mental health providers to provide services for client's needing mental health care.

2. **Do I have to have a Qualified Professional or "Q"?**
   Twenty four-hour, day treatment, and outpatient treatment facilities are required to have a Qualified Professional assist in the development of client treatment/habilitation plans to ensure treatment outcomes. The type of service you are licensed to provide and the type of clients you serve will dictate the type of Qualified Professional you must have. 10A NCAC 27G Section .0100 includes definitions, education and experience requirements of qualified professionals.

3. **Do I have to pay the Qualified Professional or "Q"?**
   There is no licensure rule requiring a mental health provider to pay for the services of a Qualified Professional, however "Q"s are professionals who generally charge a fee for their services. Payment for the services of a Qualified Professional is governed by a variety of factors including hours worked, the specific services provided, and years of experience.

4. **Do I have to be licensed before I can serve clients?**
   YES. Serving most clients without first obtaining a license is a violation of the law. Specifically, North Carolina General Statute 122C-28 states: "Operating a licensable facility without a license is a Class 3 misdemeanor and is punishable only by a fine not to exceed fifty dollars ($50.00), for the first offense and a fine, not to exceed five hundred dollars ($500.00), for each subsequent offense. Each day's operation of a licensable facility without a license is a separate offense."

5. **Do all staff need training to work in the facility or to provide services?**
   YES. All staff must be trained and competent to provide services to mental health clients. Failing to have trained and competent staff may result in poor care for clients, may place clients' health and safety at risk, may place the health and safety of the staff at risk, and may increase provider liability.

6. **How do I get people trained? Where can I send them?**
   Staff training should be provided by a person who is competent in the area in which staff need training. Training in medication administration, for example, must be conducted by a licensed registered nurse, pharmacist, or other legally qualified person as per 10A NCAC 27G .0209(c)(3). Training in client rights, including restrictive interventions must be conducted by a person trained in these areas and is qualified to train others. Training resource information is available on the Division of MH/DD/SAS web site: www.ncdhhs.gov/mhddsas/
   We also recommend your Qualified Professional as a resource for assisting, developing or performing some of the required training. Your LME may also be a resource for training resources.

7. **Do I need my staff in place for the initial licensure survey?**
   YES. DHSR will not issue a license to a provider who does not have staff in place.

8. **How much money will I get for keeping clients?**
   Reimbursement of mental health services varies according to the population served (i.e. adults, minors, etc.), the disability for which services are provided (i.e. mental illness, developmental disabilities or substance abuse problems), and the funding source used for reimbursement (i.e. Medicaid, Special Assistance, etc.). DHSR does not handle billing, funding, or client placement. Reimbursement information can be found on the Division of MH/DD/SAS web site as noted above.

9. Do you know of any consultants who can write policies?
DHSR does not maintain information on consultants who write policies and procedures for mental health providers. To recommend consultants would be a conflict of interest for DHSR as a regulatory agency.

10. What are the fees charged to open a facility?
Please see the fee portion of the application packet for this information..

11. Can facilities be licensed in mobile/manufactured home?
YES, but there are restrictions. These restrictions include: (1) .5600 and .5100 are the only two licensure categories that allow mobile/manufactured homes, and (2) the maximum number of clients is three. In addition, a waiver is required for this setting (contact Construction Section).

12. How do I clarify to the local authorities the type of facility I am proposing to operate?
Take the completed Service Categories section in the Licensure Application to your Zoning, Building and/or Fire officials. Providers of Day, Outpatient and Residential need zoning approval.
24 hour residential services must present completed application to their LME (Local Management Entity/Local Area Mental Health Agency) to request a letter of support.

13. Do I have to upgrade the facility to meet handicap accessibility?
If you provide residential services for handicapped clients, you need to provide proper accommodations. Contact your local building official for information.

14. Can someone from Construction come to look at a facility prior to my renting or leasing it?
NO. You need to review the Physical Plant requirements in 10NCAC 27G--Section .0300 to verify the facility meets the construction, space and other physical plant requirements for the clients to be served. You may, however, contact the DHSR Construction Section for specific questions.

15. Can we use a rope ladder for a second escape?
NO. A facility required to provide a second remote exit from any story must be a door with stairs meeting the North Carolina State Building Code.

16. What are the requirements for a Day Facility?
Physical Plant requirements are on page 3 of the application packet. No fees are required at this time.

17. How do I get a Letter of Support?
24 hour residential services must present completed application to their LME (Local Management Entity/Local Area Mental Health Agency) to request a letter of support.

18. When do I need to renew my license?
All licenses expire at the end of the calendar year. A renewal application will be sent in October to be returned before the end of that year with the annual fee and appropriate inspections.

N.C. Department of Health and Human Services

Division of Health Service Regulation
Mental Health Licensure and Certification Section
2718 Mail Service Center ■ Raleigh, North Carolina 27699-2718

INITIAL LICENSURE APPLICATION FOR MH/DD/SAS FACILITIES

Office use only: ***License Number:*** **MHL-_____-_____** ***FID#*** _____

1. FACILITY NAME: _____

- Name which the facility is advertised or presented to the public. This is the name that will be printed on your license. Refer to this facility name in ALL inquiries

2. FACILITY SITE ADDRESS: (NO P.O. BOXES)

Street: _____

City _____ Zip Code _____ County _____

*Facility Telephone Number (_____) _____ Fax Number (_____) _____
*must be installed and operable prior to licensing-not allowed to be a cell phone.

3. FACILITY CORRESPONDENCE MAILING ADDRESS:

Name: _____

Street: _____

City _____ Zip Code _____ County _____

Email Address: _____

4. NAME OF FACILITY DIRECTOR: _____

5. NAME OF CONTACT PERSON: _____

Title: _____

Telephone Number (_____) _____ Cell (____) _____ Fax Number (_____) _____

6. SIGNATURE OF LICENSEE OR PERSON WITH SIGNATORY AUTHORITY: The undersigned, representing the governing authority, submits information for the above named facility and certifies the accuracy of this information in accordance with 10A NCAC 27G.

Name: _____ Title: _____

Signature: _____ Date: _____

ALL APPLICATIONS MUST BE MAILED TO ABOVE ADDRESS AND MUST HAVE AN ORIGINAL SIGNATURE

OFFICIAL USE ONLY: DHSR Form 4080

Licensure Categories: _____
Licensure Recommendation: _____
Remarks: _____
DHSR Consultant: _____

7. MANAGEMENT COMPANY: If facility is managed by a company ***other than the licensee***, provide the following information about the Management Company:

Name:_____

Address:_____

Telephone Number (_____)_____Fax Number (_____)_____

8. LOCAL MANAGEMENT ENTITY (LME): List name(s) of LMEs with which the facility has a contract:

_____

_____

_____

9. LEGAL IDENTITY OF LICENSEE:

Full legal name of individual, partnership, corporation or other legal entity, which owns the mental health facility business, is required. Owner/Licensee means any person/business entity (Corp., LLC, etc.) that has legal or equitable title to or a majority interest in the mental health facility. This entity is responsible for financial and contractual obligations of the business and will be recorded as the licensee on the license. ***Please be sure to write the name of the owner exactly the same on all documents.***

(a) Name of Owner (Corp, LLC, etc): _____

Address: _____

City: _____State:_____Zip Code:_____

Business Phone #: (_____)_____Fax (_____)_____

(b) Federal Tax ID number of Owner/Licensee**:** _____

(c) Legal entity is: _____ For Profit _____ Not for Profit

(d) Legal entity is:
_____ Proprietorship
_____ Corporation _____ Limited Liability Company
_____ Partnership _____ Limited Liability Partnership
_____ Government Unit

(e) Name of CEO/President:_____Title: _____

Address: _____

City: _____State:_____Zip Code:_____

Business Phone #: (___)_____Cell# (____)_____Fax (___)_____

If the "licensee" is a corporation or partnership list the name of the Executive Officer or General Partner.

(f) Building Owner: If the above entity (partnership, corporation, etc.) ***does not*** own the building from which services are offered, please provide the following information:

Name of Building Owner: _____

Address: _____

City: _____State:_____Zip Code:_____

Business Phone #: (_____)_____Fax (_____)_____

Facility Name:____________________MHL #:___________________

10. OWNERS, PARTNERS, AFFILIATES, SHAREHOLDERS (Confidential Information for Official Use Only)

Non-Profit Companies

If no individual holds an interest of 5% or more please sign the statement below, thereby indicating this is a non-profit group.

There are **no owners, partners, affiliates of shareholders who hold an interest of 5% or more** of the licensee applying for or renewing a license:

_________________________ _________________________ ______________
Signature Title Date

For-Profit Individuals or Companies

Complete the information below on **all** individuals who are owners, partners, or shareholders holding an interest of 5% or more of the licensee listed on page 2. Attach additional pages if necessary. *We ask that you voluntarily provide your social security number with the understanding that it will be used only as an identification number for internal record keeping and data processing*
If you are the only owner, complete the information below, listing the percentage interest as 100%.

Owner or Shareholder Name: ______________________________Social Security Number: __________
Address: ____
City: ______________________________State:____________________Zip Code:____________________
Phone # of Shareholder: (________)_____________________Fax (________)_________________
Percentage interest in this facility: ______________Title: ______________________________________

Owner or Shareholder Name: ______________________________Social Security Number: __________
Address: ____
City: ______________________________State:____________________Zip Code:____________________
Phone # of Shareholder: (________)_____________________Fax (________)_________________
Percentage interest in this facility: ______________Title: ______________________________________

Owner or Shareholder Name: ______________________________Social Security Number: __________
Address: ____
City: ______________________________State:____________________Zip Code:____________________
Phone # of Shareholder: (________)_____________________Fax (________)_________________
Percentage interest in this facility: ______________Title: ______________________________________

10. EXTENSIONS IN OWNERSHIP:

North Carolina General Statute 122C-23 also requires information about "affiliates" of the applicant entity.

(a) Is the facility controlled by an organization that operates any other licensed mental health facility? Yes _____ No _____

(b) Does the applicant control any other licensed mental health facilities? Yes _____ No _____

(c) Does the applicant control other organizations that control Mental Health facilities? Yes___ NO ___

(d) If the answer to (a) or (c) above is "Yes" list the name of the other organization(s)

Organization Name: _____ Federal Tax ID Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Organization Phone #: (_____) _____ Fax (_____) _____

Senior Officer or CEO: _____

Chairman of the Board: _____

Organization Name: _____ Federal Tax ID Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Organization Phone #: (_____) _____ Fax (_____) _____

Senior Officer of CEO: _____

Chairman of the Board: _____

11. SERVICE CATEGORIES:

Services subject to licensure under G.S. 122C are shown in the table below and are **found in the Rules For Mental Health, Developmental Disabilities and Substance Abuse Facilities and Services**. All applicants (initial and renewal) must complete the following table for all services which are to be provided by the facility. If the service is not offered, leave the spaces blank.

Rule 10A NCAC 27G Licensure Rules For Mental Health Facilities	**Check Service of License**	**Beds Assigned by Age**		
		0-17	**18 & up**	**Total Beds**
.1100 Partial hospitalization for individuals who are acutely mentally ill.				
.1200 Psychosocial rehabilitation facilities for individuals with severe and persistent mental illness				
.1300 Residential treatment facilities for children or adolescents—Level II (Max. of 12 clients)				
.1400 Day treatment for children and adolescents with emotional or behavioral disturbances				
.1700 Residential treatment Staff Secure for Children or Adolescents—Level III				
.1800 Intensive residential treatment for children or adolescents (Level IV)				
.1900 PRTF – Psychiatric Residential Treatment Facility for minors who are emotionally disturbed or who have a mental illness.				
.2100 Specialized community residential centers for individuals with developmental disabilities. (Max. of 30 clients) (CON Required if ICF/MR)				
.2200 Before/after school and summer developmental day services for children with or at risk for developmental delays, developmental disabilities, or atypical development				
.2300 Adult Developmental and vocational programs for individuals with developmental disabilities				

Rule 10A NCAC 27G Licensure Rules For Mental Health Facilities	**Check Service of License**	**Beds Assigned by Age**		
		0-17	**18 & up**	**Total Beds**
.3100 Non-hospital medical detoxification for individuals who are substance abusers				
.3200 Social setting detoxification for substance abuse				
.3300 Outpatient detoxification for substance abuse				
.3400 Residential treatment/rehabilitation for individuals with substance abuse disorders (CON Required)				
.3600 Outpatient narcotic addiction treatment				
.3700 Day treatment facilities for individuals with substance abuse disorders				
.4100 Therapeutic homes for individuals with substance abuse disorders and their children (min. 3 clients)				
.4300 A supervised therapeutic community for individuals with substance abuse disorder				
.4400 Substance Abuse Intensive Outpatient Program				
.4500 Substance Abuse Comprehensive Outpatient Treatment Program				

Rule 10A NCAC 27G Licensure Rules For Mental Health Facilities	Check Service of License	Beds Assigned by Age		
		0-17	18 & up	Total Beds
.5000 Facility based crisis service for individuals of all disability groups				
.5100 Community respite services for individuals of all disability groups				
.5200 Residential therapeutic (habilitative) camps for children and adolescents of all disability groups				
.5400 Day activity for individuals of all disability groups				
.5500 Sheltered workshops for individuals of all disability groups				

Rule 10A NCAC 27G Licensure Rules For Mental Health Facilities *Only one of these categories can be checked*	Check Service of License	Beds Assigned by Age		
		0-17	18 & up	Total Beds
. 5600 supervised living for individuals of all disability groups (CON required if ICF/MR facility)				
5600**A** Group homes for adults whose primary diagnosis is mental illness (Max. of 6 clients)				
5600**B** Group homes for minors whose primary diagnosis is mental retardation or other developmental disabilities (Max. of 6 clients)				
.5600**C** Group homes for adults whose primary diagnosis is mental retardation or other developmental disabilities (Max. of 6 clients)				
.5600**D** Group homes for minors with substance abuse problems (Max. of 6 clients)				
.5600**E** Half-way houses for adults with substance abuse problems				
.5600F Alternative family living – providing service in own private residence (Max. 3 clients)				

12. DO YOU HAVE A CERTIFICATE OF NEED? Yes ☐ No ☐
Required for the following service categories: .2100, .3400, & .5600 (only when ICF/MR facility)

If yes, CON Number _____ Date _____

13. NUMBER OF CLIENTS FOR WHICH THE FACILITY IS GOING TO BE LICENSED:

Type	Specify Number to be Licensed
Ambulatory*	
Non-Ambulatory, 1-3	
Non-Ambulatory, 4 or more	

***Ambulatory: a person who can evacuate the building without physical or verbal assistance during a fire or other emergency.**

14. NUMBER AND AGE(s) OF PEOPLE OTHER THAN CLIENTS RESIDING WITHIN THE FACILITY:
(applicable only in categories where private residence is allowable: .5600 F & .5100 Private Home Respite)

_____

_____

Are any of these non-ambulatory? Yes ☐ No ☐

CONSTRUCTION: PHYSICAL PLANT

Please fill in EACH inspection Department information:

Zoning Department Official

Department Name: _____ Official's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

County: _____ Phone:( ) _____

Local Building Official

Department Name: _____ Inspector Name*: _____

Address: _____

City: _____ State: _____ Zip Code: _____

County: _____ Phone:( ) _____

Local Fire Marshall

Department Name: _____ Inspector Name*: _____

Address: _____

City: _____ State: _____ Zip Code: _____

County: _____ Phone:( ) _____

Local Sanitation

Department Name: _____ Inspector Name*: _____

Address: _____

City: _____ State: _____ Zip Code: _____

County: _____ Phone:( ) _____

***Provide Inspector's name if Inspection completed and copy attached.**

Building Information: Complete for 24-hour residential facilities only:

Has the building housed a licensed facility previously? Yes ☐ No ☐

If Yes: Type of licensed facility _____

Previous License # _____ Dates of Licensure: From _____ To: _____

Does this building(s) contain facilities licensed for a different use other than the one an initial license is being sought for? Yes ☐ No ☐

If Yes, please clarify type of license _____

Is the building a site constructed home or a manufactured/mobile home? _____

(*If it is a manufactured/mobile home – contact the DHSR Construction Section for licensure limitations on this type of structure)

If it is a manufactured/mobile home, was it built after 1976? Yes ☐ No ☐

PHOTOGRAPHS

NAME OF FACILITY: _____

COUNTY: _____

Please attach photos of your facility, as required, to this sheet and add other blank sheets as needed. **Please label each photograph as to identity of room** within the facility and **also <u>on</u> <u>the back of the photo</u> <u>identify</u> with the name and address of the facility** (to help identify picture should they get separated) Thank you.

MENTAL HEALTH SURVEY

THIS SURVEY MAY BE USED TO ASSIST YOU IN ASSURING THAT YOUR POLICY AND PROCEDURE MANUAL IS COMPLETE.

Policies and Procedures Worksheet

Facilities Licensed Under N.C.G.S. 122-C-10A NCAC --Subchapter 27G

Facility:	MHL#: -	27G Code(s):	County:

Consultant:	Date: / /	Time Begin:	Time End:

SECTION .0200 OPERATION AND MANAGEMENT RULES

.0201 Governing Body Policies	
☐ Delegation of Mgmt authority	☐ Strategies for improving client care
☐ Admission criteria	☐ Staff credentialing/privileging
☐ Discharge criteria	☐ Review of fatalities
☐ Who will perform assessments	☐ Standard of practice
☐ Assessment time-frame	☐ Medication usage – use Section .0207 for a detailed check list.
☐ Persons authorized to document in client rec	☐ Incident reporting
☐ Transporting records	☐ Voluntary non-compensated work by client
☐ Safeguarding of records	☐ Fee assessment & collection
☐ Accessibility of records to auth. persons	☐ Medical emergency plan
☐ Assurance of confidentiality of records	☐ Authorization for F/U of lab tests
☐ Assessment of presenting problem	☐ Transportation
☐ Assessment of ability to provide service(s)	☐ Safety precautions
☐ Disposition of client	☐ Volunteers-confidentiality requirements
☐ QA/QI activities and composition	☐ Staff training & CEU's
☐ Written plan for QA/QI	☐ Client grievance policy
☐ Methods of monitoring client care	☐ Infectious Disease
☐ Qualified supervision	
☐ Intervention Advisory Committee	

Notes:

.0209 Medication Requirements	
☐ Meds dispensed only by written MD order ☐ Dispensing of meds by Licensed pers. only ☐ Take-home Methadone to be given to client by Registered Nurse only ☐ Facilities shall not keep prescription drugs for dispensing w/o a Pharmacist, except for emerg. use. A small supply of samples may be kept & locked by an MD ☐ Non-prescribed drug containers not dispens. by a Pharmacist must have the original label with expiration dates visible ☐ Prescription meds. must be dispen. In tamper-resistant packaging ☐ Label on presc. meds must Include: Ct's name; MD's name; disp. date; admin. directions; name, strength, quantity, and, expiration date of drug; name and address of pharmacy, name of Pharmacist ☐ Med admin. by written MD order only ☐ Meds only self-admin by written MD order ☐ Med admin. by trained staff only ☐ 6-month drug review by a Psychiatrist or Pharmacist required if taking Psychotropics	☐ MAR must be kept current ☐ MAR must have: ct's name; name, strength & quantity of drug; instructions for admin; date & time of admin; initials of person admin. drug ☐ Ct request for med changes/checks on MAR ☐ Non-controlled meds must be disposed of by flushing, or returned to the pharmacy ☐ Controlled meds must be disposed of by the Rules in NC Controlled Substance Act GS 90 ☐ Docum. of disposal in record w/Ct's name, med. name, strength, quantity, disposal date & method, signature of disposer & witness ☐ At D/C of ct meds shall be disposed of immed. ☐ Meds must be locked ☐ Fridge meds must be in separate locked container ☐ Meds must be stored separately for each ct. ☐ Meds must be stored separately for internal & external use ☐ In a secure place for approved self-administering ☐ A facility must be registered under GS 90, Article 5 if controlled substances are on premises ☐ Staff is responsible for informing the MD of the review results if medical intervention is indicated
☐ Findings from drug review recorded in clients record w/ corrective action plan ☐ Meds prescribed by an area program MD will give written or oral instructions ☐ Med education will be enough to allow for ability to make informed consent	☐ The area program will have written docum. in ct's record that education was given, to whom & in what format ☐ Med errors are to be recorded in MAR ☐ Med refusal or adverse reactions recorded ☐ Severe reactions to be immediately reported to MD or Pharmacist

Notes:

CLIENT RIGHTS IN COMMUNITY MENTAL HEALTH, DEVLOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

SUBCHAPTER 27D-GENERAL RIGHTS

.0101 Policy On Rights Restrictions And Interventions

- ☐ Alleged/suspected-abuse/neglect/ exploitation must be reported to area DSS
- ☐ Safeguards are used when meds present an increased risk to ct. (ie-neuroleptics)
- ☐ ID prohibited restrictive interventions
- ☐ 24-hr facility-Identify circumstances when staff can not restrict the rights of clients
- ☐ ID allowed restrictive interventions
- ☐ Staff responsible for informing ct.
- ☐ Due process procedure for ct. refusing rest. inter.
- ☐ ID staff responsible for giving written permission for 24-hr restrictive intervention
- ☐ ID staff responsible for review of restrictive interv.
- ☐ Process of appeal for disagreement over planned use of restrictive interventions

- ☐ Client's physical and psychological well-being to include: review of the client's health history or comprehensive health assessment; continuous assessment and monitoring of the client's physical psychological well-being throughout the duration of restrictive intervention; continuous monitoring of the client 's physical and psychological well-being by a staff trained in CPR; and continued monitoring of the client's well-being for a minimum of 30 minutes a staff trained in CPR to
- ☐ Following the use of rest. inter. the staff shall conduct debriefing and planning with the client and legal responsible person. This process should be conducted based on the cognitive functioning of the client.

.0102 Suspension And Expulsion Policy

- ☐ No ct shall be threatened w/ unwarranted suspension or expulsion
- ☐ Policy & criteria for suspension
- ☐ Time & conditions for resuming services

- ☐ Doc. of efforts to make alternative services avail
- ☐ Discharge plan, if any

.0103 Search And Seizure Policy

- ☐ Ct should have privacy
- ☐ Policy on searches/seizures of ct's possessions (including circumstances)

- ☐ Doc. of search/seizure including: scope, search, reason, procedures followed, account of disposition of seized property

.0104 Periodic Internal Review

- ☐ Facility shall conduct a review at least every 3 years to check for compliance with applicable laws

- ☐ The governing body will keep the last 3 written reports of the findings of the reviews

Notes: _____

SECTION .0200 INFORMING CLIENTS AND STAFF OF RIGHTS

.0201 Informing Clients	
☐ Written clients rights given to ct. or guardian ☐ Each ct must be informed of right to contact Governor's Advocacy Council ☐ Within 72 hours or three visits ct's will be informed of rules, and violation penalties; disclosure rules for confidential info; procedure for obtaining a copy of treatment plan; grievance procedures (incl. Contact person); suspension/expulsion; and search and seizure	☐ In facilities using restrictive interventions-within 72 hours or 3 visits ct's will be informed of the purpose, goal, & reinforcement structure of a behavior mgmt system; potential restrictions; notification provisions regarding use; notice that the legally responsible person after use of restr. interv.; a competent adult may designate an indiv. to receive information after rest. int.; and notification provisions re: restriction of rights ☐ Doc. in record that rights were explained

.0202 Informing Staff	
☐ Written policy on informing staff of clients rights	☐ Doc. of receipt of information by each staff

Notes:

SECTION .0300 GENERAL CIVIL, LEGAL, AND HUMAN RIGHTS

.0301 Social Integration	
☐ Ea. ct. will be encouraged to participate in activities	☐ Ct's will not be prohibited from activities unless restricted in writing in ct. record

.0302 Client Self-Governance
☐ Written policy-allows ct input into facility governance & development of ct self-governance groups

.0303 Informed Consent	
☐ Ct will be informed about the alleged benefits, potential risks, and alternative treatments ☐ Ct will be informed about the length of time the consent is valid and procedure to w/d consent ☐ Consent for use of restrictive interventions valid for 6-months	☐ Written consent needed for planned interventions ☐ Written consent needed for antabuse & Depo-Provera, when used for non-FDA approved uses ☐ Ct's have a right to refuse treatment, shall not be threatened with termination ☐ Doc. of informed consent in ct's record

.0304 Protection From Harm, Abuse, Neglect, or Exploitation	
☐ Staff will protect clients from harm, abuse, neglect, and exploitation ☐ Staff will not inflict harm, abuse, neglect, or exploit ct's ☐ Goods/Services will not be sold to or purchased from ct's except through established policy	☐ Staff will only use the degree of force necessary to repel or secure a violent/aggressive ct and which is permitted by the policies. The degree of force necessary depends on the characteristics of the ct and degree of aggressiveness. Use of interventions in agreement with 10A NCAC 27D ☐ Any violation of this rule by staff is grounds for dismissal

Notes:

SUBCHAPTER 27E-TREATMENT OR HABILITATION RIGHTS

SECTION .0100 PROTECTIONS REGARDING INTERVENTION PROCEDURES

If the facility uses Seclusion, Restraints, and Isolation Time Out's this section must be checked in the rulebook and must be reflected in the facilities policy and procedure manual.

.0101 Least Restrictive Alternative

☐ Facilities shall provided services using the least restrictive, most appropriate and effective positive treatment policy ☐ The use of restrictive interventions, to reduce a behavior will be used with positive treatment or habilitation methods	☐ Treatment methods shall include: deliberative teaching & reinforcement of behaviors which are non-injurious; improvement of conditions assoc. w/non-injurious behaviors, i.e. enriched social and educational environment; alteration or elimination of environmental conditions correlated w/self injury

.0102 Prohibited Procedures

☐ The following procedures are prohibited: corporal punishment; painful body contact; substances which create painful bodily reactions; electric shock; insulin shock; unpleasant tasting foodstuffs; application of noxious substances (noise, bad smells, splashing with water); physically painful procedures to reduce behavior	☐ The governing body may determine to prohibit use of any interventions deemed unacceptable

Notes:

.0103 General Policies Regarding Intervention Procedures	
☐ The following procedures can only be used when clinically/medically indicated as a method of treatment: planned non-attention to specific undesirable behaviors when they are health threatening; contingent deprivation of any basic necessity; or professionally acceptable behavior modification procedures not prohibited by rules .0102 or .0104	☐ The determination that a procedure is clinically/medically indicated, and the authorization for use of such a treatment for a specific ct, can only be made by a physician or a licensed Ph.D. who has been formally trained and privileged in the use of a procedure

.0104 Seclusion, Restraint, and Isolation Time Out	
☐ Use of restrictive interventions shall be limited to emergency situations (to terminate dangerous behavior) or as a planned measure of therapeutic treatment ☐ Rest. interv. will not be used as retaliation or convenience of staff, & will not cause harm ☐ Written policy delineates use of rest. interv. ☐ Written policy when rest. interv. is used must be written and approved by the Commission and must follow rules 27E .0104(e)(1)(A-D) or the facility must have provisions included in the next box.	☐ (e)(2) Review of the client's health history or the client's comprehensive health assessment conducted upon admission to a facility. The assessment shall include pre-existing medical conditions or any disabilities and limitations that would put the client at risk during the restrictive intervention; continuous assessments and monitoring of the client's physical psychological well-being throughout the duration of restrictive intervention by a staff present and trained in restrictive intervention; continuous monitoring of the client's physical and psychological well being by a staff trained in CPR during the use of the restraint; and continued monitoring of the client's physical and psychological well being by a staff trained in CPR for a minimum of 30 minutes to the termination of restrictive intervention.

Notes:

.0104 Seclusion, Restraint, and Isolation Time Out (Continued)

- ☐ If the facility complies with (e)(2) then the following provisions apply: any room used for seclusion will comply with 8(A-I).
- ☐ When rest. interv. is used documentation in the ct. record will include: notation of the client's physical and psychological well being, notation of the frequency, intensity, & duration of behavior leading to rest. interv. and circumstances leading to the behavior; rationale for using rest. interv. which addresses the inadequacy of less restrictive techniques; description of intervention and date, time, & duration of use; description of accompanying positive methods of intervention; a description of the debriefing and planning with the client and legal responsible person for the emergency use of seclusion, physical restraint or isolation time-out; a description of the debriefing and planning with the client and the legal responsible person for the planned use of seclusion, physical restraint or isolation time-out; and signature & title of staff who initiated and the staff who further auth. the use of intervention.
- ☐ Emergency use of rest. interv. will be limited to: staff privileged to use rest. interv. Based on experience & training; continued use of interv. will be auth'd only by staff privileged to use rest. interv.; the responsible staff will meet with & conduct an assessment that includes the physical and psychological well being of the client & write a continuation auth. ASAP after the time of initial use of rest. interv.; verbal auth can be given if responsible staff concurs that it is justified; verbal auth. will not exceed 24 hours; and a written order for seclusion, physical restraint or isolation timeout is limited.
- ☐ When a ct is in seclusion or physical restraint they must be observed ≤ 15 minutes; ct will be allowed meals, bathing, and toilet use; both of which must be recorded in the client record
- ☐ When rest. interv. is used as a planned intervention the facility policy shall specify consent or approval valid for no more than 6 months based on recent behavioral evidence intervention is positive and continues to be needed.
- ☐ When a ct is in isolation time-out there will be staff solely to monitor client, there will be continued visual and verbal interaction which will be documented in the client record
- ☐ When a ct is in physical restraint staff will remain with the client continuously.
- ☐ Rest. interv. will be discontinued ASAP or within 30 minutes of behavior control, new auth must be obtained for rest. interv. over 30 minutes to four hours for adult clients; two hours for children and adolescent clients ages nine to 17; or one hour for clients under nine. The original order shall be renewed with these limits or up to a total of 24 hours.
- ☐ Written approval required for rest. interv exceeding 24 hours.
- ☐ Standing orders or PRN orders shall not be used to authorize the use of restrictive intervention.
- ☐ Doc of rest. interv. ≥ must be in ct record. When rest. interv. is used notification to the treatment team, & designee of the governing body, must occur ASAP or within 72hrs.
- ☐ Review & report of rest. interv. must be conducted regularly; investigations of unusual or unwarranted patterns of utilization.
- ☐ Documentation shall be maintained on a log including: name of ct; name of responsible staff; date, time, type, duration, reason for intervention, positive and less restrictive alternatives used or considered and why used, debriefing and planning conducted to eliminate or reduce the probability of future use of restrictive interv., and negative effects of the restrictive interv. on the physical and psychological well being of the client.
- ☐ The facility shall collect and analyze data on the use of seclusion and restraint on the following: the type of procedure used and length of time employed; the alternatives considered or employed; and the effectiveness of the procedure or alternative employed.
- ☐ Ct's are able to request voluntary rest. interv.

.0104 Seclusion, Restraint, and Isolation Time	Out (Continued)
☐ Rest. interv. can be considered a planned interv. and will be included in the ct's treatment plan when used: ≥ 4X, or ≥40hrs., in 30 consecutive days; in a single episode for ≥24 continuous hours in an emergency; or as a measure of therapeutic treatment designed to reduce behavior to allow less restrictive treatment. ☐ When rest. interv. is used as a planned intervention the facility policy shall specify consent or approval valid for no more than 6 months based on recent behavioral evidence intervention is positive and continues to be needed. ☐ Prior to initiation or continued use of planned intervention, written consent/approval in client record – approval of plan by professional and treatment team, consent of client or legally responsible person, notification of client advocate, and physician approval. ☐ Documentation in client record regarding use of planned intervention shall indicate: description and frequency of debriefing. Debriefing shall be conducted to the level of functioning of the client; bi-monthly evaluation of the planned intervention by the responsible professional; and review at least monthly by the treatment/hab. team that approved the planned intervention.	

Notes:

.0105 Protective Devices	
☐When protective devices are used a written policy will ensure that: the need has been assessed and the device applied by staff trained and privileged to do so; it is the most appropriate treatment; the ct is frequently observed & given opportunity to use the toilet, exercise, and is monitored every hour	☐Documentation and interventions will be recorded in ct's record ☐Protective devices are to be cleaned regularly ☐Facilities operated by or under contract with an area program will be subject to review by the clients rights committee. ☐Use of devices will comply with .0104

.0107 Intervention Advisory Committees (only if restrictive interventions are used)	
☐An Intervention Advisory Committee will be established to provide additional safeguards in a facility using restrictive interventions ☐The Intervention Advisory Committee should have at least one member who has been a member of direct services or a close relative a consumer and: for an area program facility the Interv. Advis. Comm. will be the Clients Rights Committee; in a facility not operated by an area program, the Interv. Advis. Comm. will be the Human Rights Committee; or a facility will have a committee will have 3 citizens who are not employees or members of the governing body	☐Intervention Advisory Committees shall have a member or regular independent consultant who is a professional with training and expertise in the use of the type of interventions who is not directly involved in the treatment of the client ☐The Interv. Advis. Comm. will have a policy that governs the operations and states that ct info will only be given to committee members when necessary to perform duties ☐Interv. Advis. Comm. will receive specific training & orien., be provided w/copies of related statutes and rules, maintain minutes of each meeting, and make an annual written report to the gover. Body on activities of the committee

.0201 Safeguards Regarding Medications	
☐Use of experimental drugs is research and will be governed by GS 122C-57(f)	☐Use of other drugs as a treatment measure shall be governed by GS 122C-57, GS 90 Articles 1, 4A, & 9A

Notes:

SUBCHAPTER 27F- 24-HOUR FACILITIES

.0100-SPECIFIC RULES FOR 24-HOUR FACILITIES

0101. Scope	
☐ Article 3, Chapter 122C of the General Statues provides specific rights for each client who receives a mental health, developmental	Disability, or substance abuse service. This Subchapter delineates the rules regarding those rights that in a 24-hour facility.

.0102 Living Environment	
☐Efforts to make a quite atmosphere for uninterrupted sleep, privacy areas	☐Ct may suitably decorate room, when appropriate

.0103 Health, Hygiene, and Grooming	
☐Ct will have the right to dignity, privacy, and humane care in health, hygiene, and grooming ☐Ct's will have access to a shower/tub daily or more often as needed; access to a barber or beautician, access to linens and towels, and other toiletries	☐Ct's bathtubs, showers, and toilets will be private ☐Adequate toilets, lavatory, and bath facilities equipped for use by a ct with a mobility impairment will be available

.0104 Storage and Protection of Clothing and Possessions
☐Staff will make effort to protect ct's personal clothing & possessions from loss or damage

.0105 Client's Personal Funds	
☐Ea. ct will be encouraged to maintain funds in a personal account ☐Funds managed by staff will: assure the ct's right to deposit & withdraw money; regulate the receipt and distribution, and deposits of funds; provide adequate financial records on all transactions; assure ct funds are kept separate; allow deduction from accounts for pymt of treatment/habilitation services when authorized; issue receipts for deposits & withdrawals; provide ct-quarterly statements	☐Authorization by ct required before a deduction can be made from an account for any amount owed for damages done by the ct to the facility, to an employee of the facility, a visitor, or another client

Notes: